Appt. Date_____

Pulmonary Order Form

Pulmonary Function Lab
4650 W. Sunset Blvd MS#128, Los Angeles, CA 90027
Phone: (323) 361-2287 Fax #: (323) 361-4533

PATIENT NAME: _____ DOB: _____ MR#_____

Ph: _____ Cell:_____Address:_____

Ht: _____cm Wt: _____kg BMI _____ Age: _____

DIAGNOSIS: 1. _____ 2. _____ 3. _____

Medications: 1. _____ 2. _____ 3. _____ 4. _____

Related Symptoms / Reason for Test: _____

Is patient physically disabled? NO____ YES_____ If *yes,* please explain:_____

Pulmonary Function Testing requires the ability and willingness to cooperate with specific breathing manuvers.

Is patient developmentally appropriate? _____NO _____YES Is patient able to cooperate? _____NO _____YES

PATIENT INSTRUCTIONS:

☐ Hold bronchodilators 12 hours before PFT

☐ Continue regular pulmonary medications ; including bronchodilators ☐ ISOLATION REQUIRED

TEST REQUESTED :

☐ Complete PFT's ☐ PFT – Complete pre/post bronchodilator w/ MIPS / MEPS for ventilatory muscle strength

☐ CF Protocol PFT's ☐ Complete w/ MIPS / MEPS

☐ Complete w/ bronchodilators ☐ PULM Exercise Study

☐ Spirometry only ☐ Cardiac Stress Test (ONLY, no Gas exch)

☐ Hypertonic Saline PFT's ☐ Methacholine Challenge (Requires 1 week notice for pharmacy)

☐ High altitude simulation study, routine test is 5,000 and 8,000 feet. If different altitude is desired, please specify _____.

☐ Resting Energy Expenditure (Child must be able to sit quietly and breath through a mouthpiece)

☐ Infant PFT (Pulmonary Consultation is Required)

PHYSICIAN ORDER:

☐ Give Albuterol 2.5mg (0.083% vial) per aerosol for airways obstruction.

☐ Give Xopenex 0.63% per aerosol for airways obstruction.

*Special Instructions/Considerations:_____

Referring Physician Name: _____ Phone #:_____Fax :_____

Address:_____

Physician Signature:_____ Date:_____ Time: _____

For Office Use Only

□ Authorization, insurance card, progress note attached □ OUTPATIENT □ INPATIENT

□ HMO—Auth. exp date:_____ FL_____RM_____

Med GRP/IPA:_____ Tech completing study:_____

Ins. Carrier:_____ Storage disk #:_____Reader station (d) file #:_____

□ Letter sent □ Waiting list

Previous study date:_____ ( ) copy attached ( ) not avail.

□ Incomplete Referral

Staff comments:_____

shared/sleeplabforms/dr requestforOvernightsleepstudy.doc ATTACH TO RED FOLDER